PARSONS (R. L.)

Compliments of the Author

Practical Points Regarding the Senile Insanities, with Special Reference to Prophylaxis and Management

BY

RALPH LYMAN PARSONS, A.M., M.D.

NEW YORK

LATE MEDICAL SUPERINTENDENT OF THE NEW YORK CITY LUNATIC ASYLUM; LATE PHYSICIAN IN CHARGE OF THE NEW YORK CITY HOSPITAL FOR EPILEPTICS AND PARALYTICS; MEMBER OF THE AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION, MEMBER OF THE AMERICAN NEUROLOGICAL ASSOCIATION, MEMBER OF THE NEW YORK NEUROLOGICAL SOCIETY, FELLOW OF THE NEW YORK ACADEMY OF MEDICINE; MEMBER OF THE MEDICAL SOCIETY OF THE COUNTY OF NEW YORK; MEMBER OF THE MEDICO-LEGAL SOCIETY; MEMBER OF THE SOCIETY OF MEDICAL JURISPRUDENCE, ETC.

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PRACTICAL POINTS REGARDING THE SENILE INSANITIES, WITH SPECIAL REFERENCE TO PROPHYLAXIS AND MANAGEMENT.

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Of all the mental aberrations and degeneracies, none are more worthy of the attention and study of the general practitioner of medicine than those which occur at advanced periods of life; for while under normal conditions the mental powers should outlast the physical, remaining unimpaired in their essential qualities until the end, it is nevertheless true that in many of the aged the mental faculties fail with or before the physical; and, furthermore, that many of these failures might have been prevented, or at least delayed, if wise counsels had been obtained and followed; and that no one can be so well fitted to give such counsel and advice as the family physician, who is in a position to see and duly estimate the causes which are leading to these failures. And when, in due time, the family physician shall be habitually retained as an adviser of the family in health as well as in disease, as he should be, and as lawyers are now often employed to look after the interests of the family property when it is neither in litigation nor in danger, the physician can render still greater service in warding off the mental diseases to which the aged are exposed. Another reason why this subject deserves the especial attention of the family physician is that the aged

are more disturbed by removal from customary habits and surroundings than younger persons, and a proper and laudable respect for their age and for the services of a lifetime demands that their feelings in this regard should be respected in so far as is compatible with their best interests; and so that they should remain longer under the care of the family physician than would be advisable or desirable in the case of younger persons.

We are quite accustomed to expect that mental deterioration will take place *pari passu* with the physical weaknesses that are inevitable at an advanced age. And yet we not unfrequently meet with aged persons who are on the verge of physical dissolution, but whose mental faculties remain unimpaired in quality, and as active as at any other period of life when the body is in a like state of debility from any cause. In fact, the normal brain which is free from disease, in a well-constituted body, ought to be the very last of the organs to fail in its functions. And mental force often proves itself to be the conservator of the physical forces. In proof of this, it is sufficient to note the fact that people who are apparently hopelessly ill and who are told that their recovery is beyond hope, sometimes stubbornly dissent from that view and actually do recover; and when there can be no more doubt that they would have died but for their mental resistance, than we can doubt that of two drowning men of equal physical powers one may save himself by his determination to do so, while the other is lost by his lack of mental force. And this mental force or its lack does not depend entirely on the original quality of the brain substance itself, but in part, at least, on the sort of training to which the mental powers have been subjected. If these well-constituted brains are less active in later than in earlier years, this can be readily accounted for by the fact that bodily weaknesses hinder and prevent prolonged activity; and also that

former incentives to activity no longer exist. It is generally admitted that persons of advanced age are often of better judgment than the young. Nor is it correct to assume that every failure of the memory is an evidence of failure of the mental powers. There are different sorts of memory, and some of these may fail while others persist; those which persist being the ones in which the person takes the greatest interest, or which have been oftenest repeated. And then, with increased years, the number of things to be remembered also increases, and the impressions which have been the fewest in number will naturally be the first to fail in the memory. The impressions of earlier life excited great interest from their comparative fewness in the past, or they have had many repetitions and so have induced a cell habit favoring a reproduction of the impression. Proper names—that is, specific words which are applied each to one specific person or thing—are the soonest forgotten of words, for the simple reason that they are specific, and so of infrequent application. It is only an exaggerated or an essential loss of memory in the aged which should be considered as involving the integrity of the mental faculties; as when the names of near relatives are forgotten, or when the conventionalities of daily life are no longer remembered. And it is even possible for the reasoning powers to subsist with the ability to perform the ordinary duties of daily life, when there is an entire lack of ability to construct a single intelligible sentence or to recall the names of intimate friends.

But it must be acknowledged that with the accession of the physical infirmities and changes incident to old age—the loss of muscular strength, the loss in weight, the wrinkling of the skin, the arcus senilis, the trembling of the hands, the emaciation, the failing appetite, the impairment of digestion and nutrition, the weakening of the action of the heart, the dimin-

ished tone and resiliency of the vascular system, attended oftentimes by organic changes of the vessels; the dulling of the special senses, especially of the hearing; the disturbed sleep at night, or the hebetude by day—that these, existing in varying degrees, are often attended or soon followed by important changes in the mental processes—changes which, although they cannot yet be fairly considered as pathological in character, are still an evidence of a weakness that forebodes impending danger. As examples of these mental changes may be mentioned irritability of temper, imperiousness, disturbance of the emotions without sufficient cause, or an undue diminution of emotional excitability, extreme loss of memory, great diminution of the power of attention, diminished power of abstract thought, fickleness, or perversity of disposition.

When many of these signs and symptoms are manifested in a marked degree, the border line of unmistakable mental alienation cannot be far distant. But it should not be inferred that the border line must of necessity be passed. Under wise advice and suitable conditions, the crisis may never be reached; and the reason may be conserved, without essential impairment, until the end. Nor should it be inferred that because the border line has unmistakably been passed, a recovery is impossible on account of the advanced age of the patient; for, in fact, the aged are nearly or quite as likely to recover from an acute attack of insanity as those persons who suffer an attack at other periods of life, when the ratio of persons living at this period is taken into consideration.

And at this point it is well to note that senility is not altogether a matter of years. Some persons are physically and mentally as old at fifty as others are who are ninety or even a hundred years of age. Some families have greater vitality than others; and so their members are likely to live a greater number of

years and to become senile later in life. The age to which any individual can possibly survive under the most favorable conditions depends upon the amount of vitality he has inherited from his ancestors. This amount can never be increased, although it may be and often is diminished. And herein lies the indication for means to delay the approach of premature senility and decay, whether on the physical or on the mental side—the removal of influences which are prejudicial and the substitution of those which are advantageous.

The acute mania of the aged differs so little from the acute mania of earlier years as to require only a passing notice, save that the physical resistance to prolonged excitement and loss of sleep is sometimes marvellous. Complete recoveries are not infrequent; and these may be enduring or may give way to subsequent attacks. The maniacal attack is often preceded by a period of mental depression.

The cases of mild maniacal exaltation that are sometimes observed in the aged usually have their origin at an earlier period of life, and cannot be considered as characteristic of senile insanity.

Melancholia in the aged is more insidious in its onset, and may be either a simple mental depression, melancholia without delusions; or it may be characterized by insane delusions. In either form suicidal impulses are common. The simple form of the disease is of frequent occurrence, and recoveries are also frequent. It should be noted, however, that such false ideas, as that some great calamity is impending, that they are becoming impoverished, that they have ruined their friends, that their souls are lost, or that they have committed the unpardonable sin, should not be ranked as essentially insane delusions—that is, as delusions which are in themselves diagnostic evidences of insanity. The essential characteristic of this form of insanity is the emotional depression.

The gloomy ideas are the direct outcome and result of the depressed emotions, and not their cause.

In the delusional form of melancholia, in the aged no less than in earlier life, the delusions are of an essential character, as that their most devoted friends have become their malignant enemies, that their food is being systematically poisoned, that they are to suffer a violent death, or that their bowels are inhabited by snakes. Incredible delusions of this sort are indicative of a profound mental degeneration, and recovery is very much more rare than in the simple form.

If recovery from these acute forms of senile insanity takes place, subsequent attacks are liable to follow, especially if care be not taken to avoid the exciting causes. The same predisposition which was the basis for the first attack must still persist, and in a brain already weakened by the previous attack. If recovery does not take place, the patient usually passes into a condition of consecutive dementia, from which recovery is not to be expected.

The typical insanity of the aged is a primary dementia, which differs from the primary dementia of earlier life in that it is incurable; depending, as it does, on organic changes in the tissue of the brain. Primary senile dementia is in many particulars similar to general paresis, its characteristic condition being one of weakness.

Oftentimes this form of senile insanity is very insidious in its onset. In the earlier stages it may be very difficult to distinguish the approaches of a dementia which leads inevitably to a condition of fatuity, from the mere lack of mental activity which accompanies the physical infirmities of the aged while the reason still remains unimpaired. In this stage of the disease the demented person often performs acts which are foolish in the extreme, and which may lead to serious medico-legal complications. He becomes penurious, depriving himself of the comforts and nec-

essaries of life, or he disposes of his property without reason or consideration; he makes unwise marriage engagements, or makes improper proposals to women, or, more likely, he makes indecent assaults on little girls. The sexual instinct often persists in the aged dement when the power has become nearly or quite extinct.

Later on, both body and mind inevitably fail in strength, especially the mental powers. The dement then wanders aimlessly about, meddling with whatever comes within his reach, or he busies himself with placing and replacing articles without value. He loses all ideas of the conventionalities of life, of decency, of persons, and of places; he removes his clothing, urinates in a corner of the room, or he passes his excrements unconsciously; or he becomes utterly stupid and apathetic, with, perhaps, alternations of excitability and depression. And from this condition there is no reprieve until the end.

The causes of the senile insanities, some of which are coincident with the causes of the other insanities, may be conveniently considered under three categories —those which are so remote as always to have been practically beyond our control; those which are in action at the earlier periods of life; and those which are in action when senility is already impending.

There can be no question that heredity and congenital influences are important factors in determining the mental status in any period of life. If these influences are beyond our control, their consideration may be an important aid in making our prognosis and in advising such measures of prophylaxis as may be required.

The second class of causes is also worthy of consideration, not only with reference to prognosis, but also because, although somewhat remote, they may still be controlled or modified if only timely advice be given and heeded; and it is at least barely possible that

here and there a person may be found who will profit by advice bearing on the yet remote future. These causes are, for the most part, such as tend to produce organic changes in the vessels of the brain or to bring about a state of exhaustion of the physical or mental powers—as chronic alcoholism, syphilis, gout, rheumatism, venereal excesses, great and prolonged physical strain, intense and long continued mental application, with anxiety or worry; and lack of self-control, as indulgence in the passions of grief or of anger. A mere mention of these causes is enough to suggest the measures of prevention that may be required. On the other hand, a life of self-control and moderation in all things is the best possible safeguard against a premature breakdown in advanced life.

The causes, however, which are in operation when at a somewhat advanced period of life the infirmities of age begin to make themselves felt are of more immediate importance; because the advice of the physician is then more likely to be sought and followed. Some of these causes are the same as those pertaining to an earlier period of life, and are only of more importance now because the power of resistance has been diminished. Others are especially pertinent to the advanced period of life. It will be a matter of convenience to consider measures of prophylaxis in connection with each, in turn.

When the physical powers begin somewhat to fail, with advancing years, giving notice of the greater disabilities that are soon to follow, there is oftentimes a great disinclination to heed the warnings thus received; a tendency to engage in exhausting labors in competition with those who are still in the prime of life, and to encounter hardships and exposures which might have been borne with impunity in earlier years, but which now involve a strain which is likely to prove injurious in its results. There seems to be a sort of pride in appearing not to have lost anything of

pristine vigor. Although it may be evident enough to others that a moderate pace should now be taken, advice to this end will usually be required.

But the opposite extreme should also be avoided. The entire giving up of accustomed physical activities may be even worse than their continuance. It is often observed that those who suddenly and entirely cease from their accustomed work fail more rapidly than do those who continue their labors, only there should be a diminution in the amount and hours of physical activity, in due accord with the bodily failing and disabilities.

Although mental work with a well-constituted brain may usually be continued more fully and later in life than physical work, this should also be diminished with advancing years; both because the brain then requires more rest and more time for recuperation, and also because severe mental work is of itself exhaustive of the bodily powers. But here, also, an entire giving up of mental work may be more injurious than its full continuance. What is required is a continuance of mental activity with such changes in amount and quality as are in accord with its diminished powers of endurance. And these changes in habit, both mental and physical, should be made not after this has become compulsory through loss of ability, but when the first intimations of the coming necessity begin to make themselves observed and felt.

Among the premonitory symptoms and the immediate causes of insanity in persons who are becoming old, lack of proper and sufficient food and lack of sufficient sleep are prominent. With advancing years, a certain degree of insomnia comes on, the nights are restless, and so the sufferers from insomnia remain sitting up or wandering about, because they thus seem to be less uncomfortable than when tossing about in bed with inability to sleep. When they finally lie down and fall asleep, their sleep is disturbed and

unrefreshing, and they awaken with or before the early dawn, having secured only a moiety of the sleep they really require; or, after an almost restless night, they fall asleep after daybreak, when others are just beginning the occupations of the day. And thus the vicious circle is commenced of turning night into day and day into night, with all its inconveniences and drawbacks; for the nighttime, with its quietness and freedom from causes of disturbance, is a much more favorable time for normal, restful sleep than the daytime, with its many causes of disturbance. And yet, if sleep will not come at night and does come by day, this is certainly better than no sleep at all. But every possible means should be employed to break the vicious cycle and to secure a sufficient amount of restful sleep during the hours of night. It will often be found that a short nap taken once or twice during the day will favor better sleep at night, by relieving the nervous irritability which tends to prevent sleep.

And then there are many things that the aged sufferer from insomnia may do to promote sleep. A warm bath taken just before retiring, with cold applied to the head, may be an efficient aid. A cold douche to the feet and legs, or a wet pack to the abdomen, is sometimes useful. A light supper just before retiring is usually of advantage.

Babies and brute animals are usually somnolent when their stomachs are well supplied with food, the activity of the stomach withdrawing the excess of blood from the brain, where it is not needed during sleep. On the other hand, people who are very hungry usually find it difficult to sleep. And, then, a habit of sleep at a regular time and during proper hours should be cultivated in case this habit has been lost. In accomplishing this, the attainment of a favorable state of mind is of great importance. Sleep cannot be enforced by a direct exercise of the will. The very effort of the will to command sleep is enough

to render its attainment nugatory. The mental state to be encouraged is one of quiescence, one of indifference, a feeling that the recumbent posture is a proper one for rest, and that if the thoughts are disposed to continue active they may be safely allowed to take their course without any effort toward control. This state of mind and thought is next akin to dreams, and dreaming is next akin to sound sleep. Many mental methods have been advised and put in practice for the purpose of securing sleep, the design being to turn the thoughts from objects of interest to a condition of monotony: as by mentally repeating well-remembered phrases or sentences, or by counting. But the state of indifference, if this can be obtained, is likely to be the most efficient, as being the least active. The mere mention of these simple methods will be sufficient to suggest others equally effective.

Equally important with restful sleep is the taking of a sufficient amount of nutritious and easily digestible food at proper intervals; for one of the usual forerunners of a mental breakdown is loss of appetite or neglect in the taking of food. Not that the stomach should be overburdened with food, for this, too, would be prejudicial: but that a sufficient amount of suitable food for the purposes of nutrition should be taken at proper intervals. If the nights are restless, a glass of milk and a biscuit may often be taken with advantage on awaking in the middle of the night or toward morning: or a glass of warm milk in the early morning before rising.

In case an actual attack of insanity should supervene, one of the first questions to arise will probably be whether the patient can be better treated and managed at home and among his own friends or away from home. The conditions and circumstances vary so greatly in different cases that each one must practically be considered by itself. In a general way it may be said, however, that the acute cases usually do

better under skilled treatment away from their homes and their intimate acquaintances. And since these patients have a fair prospect of recovery, they should be given every advantage that tends to secure this desirable result and without too much regard to their feelings or wishes in the matter. If it is decided, however, to treat them at home, their domicile should be made a private hospital, in so far as may be required for their successful treatment, or until all reasonable expectation of recovery has passed away. Especial attention should be given that they get sufficient food and sufficient sleep; and inasmuch as the melancholics almost always have suicidal propensities, these should always be under efficient supervision. In case food is persistently refused, resort should be had to forcible feeding; and there should be no unnecessary delay in doing this, for the longer the delay the more obstinate is the refusal likely to be, while with delay the physical powers are liable to become too much impaired to admit of recuperation. But, before resort is had to forcible feeding by means of the œsophageal or the nasal tube, every possible means should be employed to induce the patient to take food with something of volition, by persistent and strong persuasion, or by an assurance that force will certainly be used if required. If forced alimentation be required, the œsophageal tube has the advantage of being safer and of admitting the use of more solid food, an advantage in itself if the feeding is to be long continued. In addition to the means already mentioned for securing sleep, drug treatment may now be advisable; the various well-known hypnotics being employed in turn, in order to avoid the danger of establishing a tolerance for any one of them and thus limiting the means of relief at our disposal. Another reason for a frequent change in the hypnotic drugs administered is that, inasmuch as all potent remedies have their disadvantages, each in some particular way,

as well as their advantages for the specific need, the disadvantageous action of the remedies will be distributed and thus reduced to a minimum. Opium is rarely to be recommended as a hypnotic. It may be of use, however, in very small doses, as a stimulant in cases of melancholia.

The wet pack is also sometimes useful, acting as a revulsive from the head, relieving the dryness of the skin and at the same time securing a state of bodily quiescence which is favorable to sleep. The application of some form of the electric current, or suitable massage may also be of advantage. Those little monotonous attentions which are well known to be so soothing in the care of restless children should not be forgotten. The mere presence of the nurse as a bedfellow, with a hand resting on the person of the patient, may afford a sense of security or relieve a sense of lonesomeness, and so promote sleep.

It is always to be understood, as a matter of course, that all concurrent and intercurrent diseases will be treated in accordance with the requirements of each.

The decision of the question whether the subject of senile dementia should be treated at home depends chiefly upon two considerations: First, whether this can be done without too seriously compromising the welfare of other members of the family; and secondly, whether, all things considered, the patient can be made as comfortable and as happy as at some available place elsewhere. But, there may be no suitable home; there may be neither relatives nor friends who are willing and competent to undertake the necessary supervision and care; for, however kind and willing the friends of the patient may be, the task may involve too great a strain upon their sympathies and on their powers of endurance. Or, as often happens, the patient may be less tolerant of the necessary measures of care and restraint at the hands of relatives than at the hands of others. All these

considerations should be carefully taken into account by the physician who is called upon to advise. If, however, these two questions can be answered in the affirmative, inasmuch as a cure is no longer to be expected, there can be no doubt that such of these patients as have a home and devoted friends ought not to be removed elsewhere for care and treatment.

It often happens that the relatives of the aged demented are quite competent to give all the care and nursing that may be needed. If not, suitable nurses should be employed; and, even for the care of men, female nurses are to be preferred, if competent for the performance of the required duties. Or if, as sometimes happens, kind-hearted neighbors volunteer their services as nurses, these untrained volunteers, as well as the family of the patient, need to be especially instructed regarding the nature of the service to be done. A neglect of this precaution has sometimes led to disastrous results, from a failure in the proper observance of sanitary measures, when the patient has become bedridden and can no longer control his evacuations. And so instruction will usually be needed in regard to the proper ventilation and cleanliness of the apartment occupied by the patient; the removal of carpets, curtains, and upholstered furniture; the immediate removal of all evacuations and other sorts of filth; scrupulous cleanliness of the person; the prevention of bedsores, and so on. In other respects, no special experience is required for the proper management of this class of patients.